Addressing Adverse Childhood Experiences with Evidence-based Care: Tripp Ake and Lisa Amaya-Jackson

Interview conducted by Kaitlin Ugolik Phillips

Childhood trauma can have lasting impact throughout the life course, affecting both physical and mental health. But it doesn't have to be this way. To better understand the role of adverse childhood experiences (ACEs) as indicators of health, the *North Carolina Medical Journal* **sat down with George (Tripp) Ake, PhD, and Lisa Amaya-Jackson, MD, MPH, two state experts in child traumatic stress.**

Introduction

George (Tripp) Ake, PhD, is a licensed psychologist and associate professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center. He is also the program director for the UCLA-Duke National Center for Child Traumatic Stress and director of training at the Center for Child & Family Health in Durham. **Lisa Amaya-Jackson, MD, MPH**, is a child psychiatrist and tenured professor in Psychiatry and Behavioral Sciences at Duke University Medical Center. She also serves as an associate director of the National Center for Child Traumatic Stress and director of Duke Psychiatry's Evidence-based Practice Implementation Center.

Kaitlin Ugolik Phillips, managing editor of the *North Carolina Medical Journal*, sat down for an interview with Ake and Amaya-Jackson to discuss their work researching and addressing the impact of adverse childhood experiences (ACEs).

NCMJ: Dr. Ake, can you help folks who may only think of "ACEs" as cards in a deck understand what we mean by adverse childhood experiences?

Ake: *The term ACEs is meant to refer back to the adverse childhood experiences study that was done about 20 years ago [1]. This particular study is one that was groundbreaking at the time, trying to really help us understand the connection between negative life experience or adverse life experience and early childhood and school age years, and that impact on physical health.*

NCMJ: There seems to have been jump in attention to ACEs and childhood trauma and their impact on health in recent years. Dr. Amaya-Jackson, can you discuss why that is?

Amaya-Jackson: *I think there's now more of a connection to the health outcomes that's been made by professionals across the country, including those who are in the National Child Traumatic Stress Network; by the ACE study authors themselves; and by Dr. Nadine Burke Harris, who is now California's surgeon general. They are bringing awareness to the fact that there is a high prevalence of these traumatic events happening in children's lives. This knowledge builds on a growing foundation that we now have. We now have genetic studies as well that join the research showing these adverse experiences can lead to significant outcomes with not only mental health but also physical health, and our policy makers are becoming more aware of this [2, 3]. From the tragic events on September 11, to Hurricane Katrina, to the current pandemic, to the many other disasters and now recognition of historical (racial) trauma, these events—particularly those of an interpersonal nature—have led to a growing recognition in this nation that these consequences are very significant and seriously affect our children, their livelihood, and their development trajectories.*

NCMJ: Do you think we are measuring ACEs in the best way? Are there other ways to measure, aside from self-report by adults of their childhoods and parental reports of children's experiences?

Ake: *We have stories of kids who've been waiting for someone to ask them, interfacing with lots of different health and mental health professionals, and no one has asked the question. So, it's really important to think about how we embed trauma screening into our day-to-day practice so that it's a normal part of our practice, just like any other screening. Thinking about the way that we use that screen data, and even the way that we collect it: how do we do it in a trauma-informed way, and how do we make it routine so kids know we didn't just single them out to ask these questions?*

Then also, we're thinking about working within our systems, like the child advocacy centers in North Carolina and other states that collaborate with other service systems, so that kids don't

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have to be asked questions multiple times. These are things that predated ACEs, but now what we're seeing are more service systems embedding screenings in what they do.

Amaya-Jackson: *We think about measuring ACEs in terms of research and epidemiology so that we understand, within populations, how many children are being affected by these kinds of situations. How do we know as a community, as a state, as a nation what we're dealing with, and what kind of services and policy do we need to set? And the other question that is being raised is how to best "measure"—screen and/or assess so that we understand if and how trauma and ACEs are occuring at the individual level of a child and family. We know it helps to talk to the parents, we know it helps to talk to their teachers, we know it helps to talk to other people in their lives. We also know to directly ask the children themselves—in a safe place. I think the issue of self-report has occasionally been raised—are people remembering things correctly? I think if you're asking a child very directly what's happening to them, they're going to give you that answer, just as Dr. Ake mentioned earlier. And we need to not just ask the question, "Have they had an adverse childhood experience?" but the equally important question about impact, even if it is being done as part of a screening process, is, "Are they having distress?"*

NCMJ: Is it true that having a stable, safe adult in your life can really offset a lot of the negative outcomes of ACEs?

Ake: *Yes, a lot of the resiliency literature and protective factor literature talks about one caring, consistent, caregiver and the impact that can make in a really positive direction [4, 5]. But also, really knowing to what extent kids have been exposed and what symptoms they have is also really important, because it changes not only what referrals you'll make, but what you do day to day when you interface with that child.*

NCMJ: Both of your work has focused on evidence-based treatments (EBTs). Can you talk a little bit about what they are and why they're important?

Amaya-Jackson: *First and foremost is the therapeutic alliance that is built into all good treatment: someone is there who can ask, who can listen, who can tolerate, who can validate, who can support the child and their family and the contextual/cultural values around them. The critical elements of trauma treatments are based on years of sound practice and research; many of these elements have been done by providers for years, but not always systematically or with skill. EBTs ensure that these different elements come together in a psychologically sound treatment package, and that package has been tested and validated in rigorous ways. It has been researched and we know that it's not just what some therapist has picked up because it sounds good, but is actually something that we know works and helps the child.*

What we're learning more and more about these EBTs is that they continue to evolve, often iteratively. As we continue to learn from the research and continue to have community members interface directly with the people developing the EBTs, we can learn to better address and include things that have historically not been part of these treatment packages, such as racial trauma, social injustice, or a pandemic.

NCMJ: "Evidence-based" suggests a level of certainty. One question folks outside this field may have is: If these are the evidence-based things, why aren't they already the standard?

Ake: *It takes years from the time an intervention has been developed to the time it's being used, and by that point the evidence has changed. To me, that's where implementation science enters into the conversation. How do we expedite these things?*

Implementation science is focused exclusively on all those different factors that help agencies and individuals bring on a new intervention, use it well, and continue using it. It's the opposite of training as usual. In the medical field we often say we want to make sure folks are trained. We do an online course with them or bring in a great speaker or have a two-day intensive training, and then people are confused about why, after that great investment, people are not using the intervention that they were trained on. I think there's a growing number of professionals that are wrapping their mind around this and would love for us to be able to break that cycle.

Amaya-Jackson: *I totally agree, and I just want to add how lucky we are to be here in North Carolina where there's a number of organizations that are devoted to working with children who've experienced trauma while also attending to the implementation barriers encountered by providers as they try to deliver it in different organizations and in different settings. I want to highlight the North Carolina Child Treatment Program, which is part of the Center for Child and Family Health in Durham, which is funded by our state and Dr. Dana Hagele is the current director. The EBT trainers do not believe in training that is just one-time, stand-up-in-front-of-the-room. They and their team work intensively to address many different kinds of barriers so that providers in their agencies have the ability to deliver these treatments to children across the state, whether they're rural, whether it's been due to community violence in an urban setting, whether it's related to disasters in their community, or to abuse at the hands of a parent.*

NCMJ: We've been talking about implementation at the clinician or individual level. At the recent North Carolina Institute of Medicine annual meeting, one panelist suggested that we need more resilient systems and policies, not just resilient kids. How do you respond to that?

Ake: *I think that's such an inspirational idea. We have a North Carolina Trauma-Informed Community Project at the Center for Child & Family Health to try to help answer these questions for communities about what it looks like, knowing that the resources look different. How do we create a similar set of values to make sure that we're on the same page? Every one of our 100 counties looks different. I think as far as policies are concerned, having some flexibility so that folks can innovate and try things out and policies don't prevent innovation is really important. Then on the other side, making sure that we educate*

well when a policy is supporting a trauma-informed practice and people can replicate that.

Amaya-Jackson: *I would add that "strengthening resiliency" to me also means amplifying the positives and making sure that those nurturing relationships, those supportive parents and caregivers, those supportive community members, are available and accessible. For parents, it helps them to be aware of the negative experiences they've had that impact their children, but it's also important for them to remember positive things that happened in their lives that affirmed them as adults, that affirmed them as parents.*

While I admire the term "resiliency" and I love "strength-based" approaches, I also feel that when you are working with children, particularly children who have experienced not just one but multiple adverse child experiences and traumas, being "resilient" will not always be possible. Setting expectations (unintentionally) that they should try to be resilient can be a burden. Not everyone who has survived horrific life events will have the things they need to be fully resilient to stress outcomes, symptoms, or poor coping. They need to be able to acknowledge that they've had something very difficult happen to them and that we can help with solid interventions and by leveraging the positive things in their lives. We do know what to do in so many different ways—we can intervene by providing treatment, reducing risk factors, and enhancing family and community support in ways that can keep the ACE story heading in a different direction than the big negative outcomes seen in the retrospective study.

NCMJ: One way I've heard it said is that having an ACE, or more than one ACE, is not a life sentence.

Ake: *I think sometimes when I hear people talk about resiliency, they are putting it on the opposite end of a continuum from what they believe trauma-informed practice is. The reality is that trauma-informed practice includes promoting resiliency and protective factors.* NCMJ

Find more about the work of Drs. Amaya-Jackson and Ake, as well as resources for measuring and treating symptoms of ACEs, at the following websites:

Duke Psychiatry & Behavioral Sciences
https://psychiatry.duke.edu/
Center for Child & Family Health
https://www.ccfhnc.org/
National Child Traumatic Stress Network
https://www.nctsn.org/
North Carolina Child Treatment Program
https://www.ncchildtreatmentprogram.org/
California Evidence-based Clearinghouse for Child Welfare
https://www.cebc4cw.org/

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